MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
WIC AND NUTRITION SERVICES

WIC CERTIFICATION - INFANT/CHILD

AGENCY

☐ ADDITION ☐ RECERT

INFANT/CHILD

SCLR

DCN | LAST NAME | SUFFIX | FIRST | MIDDLE

RACE
1 - WHITE 2 - BLACK/AFRICAN AMER. 4 - AM. IND./ALASKAN
5 - ASIAN 6 - NATIVE HAW/PAC ISL

ETHN HISP Y N | SEX M F | BIRTHDATE | AGE | SOCIAL SECURITY NUMBER

PARENT/GUARDIAN(S)

DCN | LAST NAME | SUFFIX | FIRST | MIDDLE | MAIDEN

RACE
1 - WHITE 2 - BLACK/AFRICAN AMER. 4 - AM. IND./ALASKAN
5 - ASIAN 6 - NATIVE HAW/PAC ISL

ETHN HISP Y N | SEX M F | BIRTHDATE | SOCIAL SECURITY NUMBER

COMMON DATA SYSTEM ID 02

H201 ADD
H202 UPDATE

FAM. SIZE | FAMILY INCOME W M A $ | FIN. ELG. Y N A X | MOHN Y N | MOHN CASE MANAGED Y N U | FOOD STAMPS Y N | FOSTER CARE Y N U | TANF Y N U

STREET ADDRESS | CITY | STATE MO | ZIP CODE

PHONE ( ) | MESSAGE PHONE ( ) | MOTHER/FEMALE GUARDIAN EDUCATION LEVEL B G (BIOLOGICAL/GUARDIAN) | COUNTY OF RESIDENCE

HEALTH HISTORY

H224 ADD
H225 UPDATE

AT BIRTH CROWN-HEEL LENGTH /8(IN) /10(CM) | AT BIRTH WEIGHT (LBS/OZ) (GMS) | IMMUNIZATIONS REVIEWED 0 1 2 3

UPDATE UNTIL 24 MONTHS OF AGE (ADDS AND RECERTIFICATIONS)

FEEDING DATA

IS INFANT CURRENTLY BEING BREASTFED? Y N — IF YES, FULLY OR PARTIALLY? F P

WAS INFANT EVER BREASTFED? Y N — IF YES, HOW LONG (M) MONTHS (W) WEEKS

AGE REC'D FORMULA/MILK AS A REGULAR NUTRITION SOURCE? (WKS.): 0 (NEVER) (WEEKS) 1 2 3 4 5 6 7 8 (≥8) 9 (UNKNOWN)

WIC ELIGIBILITY CLIENT DATA

H422 RECERT/REASSESS
H427 INQUIRY
H421 ADD
H423 UPDATE

CAPE SITE | PROG. I C | MIGRANT M | SPECIAL STATUS H T O | CONTACT DATE | TYPE OF CONTACT T W | SEEING PHY. Y N | DIET ASSESS. Y N | LEAD TEST Y N | HOUSEHOLD SMOKING? Y N

HEALTH ASSESSMENT DATE | HEIGHT/LENGTH /8(IN) /10(CM) | WEIGHT FOR CHILD /4(LBS) /10(KG)

WEIGHT FOR INFANT (LB/OZ) (GMS) | HEAD CIRCUMFERENCE /8(IN) /10(CM) | HEMATOCRIT /10 | HEMOGLOBIN /10 | BLOODWORK DATE

ORAL ASST. Y N | MED. ELIG. Y C M | RISK FACTORS | PRIORITY | FOOD PKG. | SEQ. | CYCLE 1 2 3

SERVICE DATE | RECERT. DATE | BMI | CPA INITIAL | NEW FPC | NEW SEQ | NEW CYCLE

REFER TO (CIRCLE): IMMUN CHILD ABUSE PHY COM BASED DNTL HLTH OTHER HCY NO REFERRAL NEEDED TANF FD STAMPS MOHN HD START SHCN LEAD

SIGNATURE (INCOME ASSESSMENT) ▶ | TITLE | DATE | GA WEEKS AT BIRTH

SIGNATURE - (RISK ASSESSMENT) ▶ | TITLE | DATE

DATE ID FOLDER GIVEN | DATE FOOD LIST GIVEN | WIC-30 CERT. PERIOD | WIC-30 LOCATION

I received the WIC Participant Identification Folder and the WIC Approved Food List on the dates listed above. I was advised on the specific requirements listed in both items.

I certify the information and documentation I provided and was recorded on the WIC Proof of Eligibility Form (WIC-30) for my household is true to the best of my knowledge. If all documentation is not available at certification, I agree to furnish it within 30 days to remain on the program and receive benefits.

I have been advised of my rights and responsibilities under the WIC program. I certify that the information I have provided for my eligibility determination is correct, to the best of my knowledge. This certification is being made in connection with the receipt of federal funds. Program officials may verify information on this form.

I understand that intentionally making a false or misleading statement or intentionally misrepresenting, concealing or withholding facts may result in paying the state agency, in cash, the value of the food benefits improperly issued to me and may subject me to civil or criminal prosecution under the state and federal law.

PARTICIPANT/CAREGIVER SIGNATURE ▶ | DATE